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ABSTRACT

The author traces the case histories of five anorexic female patients treated in the therapeutic milieu in a psychiatric inpatient unit. The history of anorexia nervosa is reviewed, incidence of the disorder is cited, and common characteristics are described. Case histories are presented in terms of events precipitating the weight loss, behavior and treatment in the inpatient unit, and finally, release from the unit. The milieu treatment program is reported to include field trips, diary keeping, tutoring of younger patients, and classroom management procedures. (SBH)

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ANOREXIA NERVOSA

by

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July 28, 1980

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ANOREXIA NERVOSA

"Fat and skinny had a race
all around the pillow case.
Fat fell down and broke her face.
Skinny said, "Ha-Ha, I won the race."

Steven Levenkron

Anorexia Nervosa is one of the most baffling mental disorders in existance. If one has the propensity for overindulging in the tangible results of the culinary arts, it becomes even more mystifying. I have been involved as a Special Education teacher and in the treatment process of girls affected with this disease on the Psychiatric Inpatient Unit of Children's Medical Center in Dallas, Texas over the past seven years. Each case repetitively aroused feelings within me that had to be examined and very harshly dealt with as I worked with those patients, who behaved in such a bizarre manner. Their actions were diametrically opposed and offensive to my orally fixated psyche. The tape constantly playing in my head said "Eating is loving, you must clean up your plate, you must eat or you will get sick", and "half of the world is starving!" I would have to constantly keep check on my verbal and non-verbal communications because I was dealing with a human being which resembled a skeleton who was barely alive. If I conversed about food with this child, who saw herself as a hopelessly and repulsively obese person, I would become the very enemy who must be kept out of her world and who must be avoided at all costs. To watch these children refuse to do the very thing which would keep them alive and to not mention eatting took all the strength I could muster.

Anorexia (loss of apetite) nervosa (due to nerves) was reported as early as 1689 in London by Richard Morton in his Pythisiologia or A Treatise of Consump-

tion. (5) He very graphically describes an 18 year old female who came to him in July, 1684 for treatment of "phthisis nervosa": 'In the month of July she fell into a total suppression of her Monthly Courses from a multitude of cares and passions of her mind, but without any symptoms of the Green-Sickness following upon it. From which time her appetite began to abate, and her digestion to be bad; her flesh also began to be flaccid and loose, and her looks pale....and he was wont by her studying at night, and continual pouring upon books to expose herself both day and night to the injuries of the air....I do not remember that I did ever in all my practice see one, that was conversant with the Living so much wasted with the greatest degree of a consumption (like a skeleton only clad with skin) yet there was no fever, but on the contrary, a coldness of the whole body.....only her appetite was dimished, and her digestion uneasie, with fainting fits, which did frequently return upon her." (15) Rejecting the medications, as do some modern anorexics, she died three months later.

Anorexia surfaced again 100 years ago as a clinical entity with independent reports by W.W. Gull in London and Lasegue in France. Gull called it "anorexia nervosa", (8) the term most generally accepted in English-speaking countries and Lasegue referred to it as "anorexia hysterique."(13)

The etiology of anorexia nervosa has traveled down a perplexing and puzzling "yellow brick road". The first publications referred to nervosa as a "disturbance in the brain of in mental functioning." (1) The French conceptualized it in Lasegues time as an "inherited degenerative disorder" (2) and Gull's concept was more functional in the direction of "mental stress and exhaustion." (3) Dr. Hilde Bruch, Professor of Psychiatry at Baylor College of Medicine in Houston, feels that even with progress made through psychoanaltric thinking, "which emphasized disturbing life experiences that result in unconscious psychic conflicts and abnormal mental

functioning; (4) the patient still must be made aware of the impulses orginating within her for successful treatment. Dr. Julian Lieb, Assistant Professor of Psychiatry at Yale University School of Medicine at New Haven Conneticutt, adds yet another brick to the road when he reports that "recent research has implicated a malfunction of the hypothalmus as a possible cause of anorexia nervosa, and some investigators have reported successful drug treatment". (14)

We are now discovering that the disease is much more common than has ever been suspected and 80% of those effected are females usually in their early teens. (21) Even though "five to fifteen percent of known victims of anorexia have starved to death despite treatment", (22) it is generally regarded as a treatable disease.

Most physicians base their diagnosis on the following criteria: "(1) Onset of symptoms before the age of 25; (2) loss of at least 25% of original body weight, leading to emaciation; (3) a negative attitude toward eating and food; weight cannot be overcome by hunger, threats or reassurance that the patient is not fat; (4) no other medical or psychiatric disease that can adequately explain the weight loss; and (5) any four of the following: periods of hyperactivity, such as overindulgance in exercise; self-induced vomiting or excessive use of laxatives; a belief that an emaciated appearance is acceptable and desirable; a history of being overweight; cessation of menstrual periods (as a result of weight loss); abnormal reactions, such as not being tired after vigerous exercise, or absence of hunger despite not eating; preoccupation with diets and occasional bouts of excessive eating, usually followed by induced vomiting; a morbid fear of being fat". (12)

Certain characteristics are common to the case histories of anorexic females. (Most authorities agree that true anorexia "is rare in boys, who come down with only one-tenth as many cases as girls".) (6) The families of anorexics are usually upper-middle class families and typically both parents have college degrees. The patient

has usually been a model child. Dr. William Nolen relates the history of a typical patient as described by her parents, "and she's never given us any trouble. In fact, sometimes we're worried that she's too good. She's an excellant student, always does her homework, never misses swimming or band practice, even keeps her room clean. I guess I'd call her compulsive. For the last month she just won't eat..... she'll sit down and pretend to eat with us, but all she does is move the food a-round on her plate so that it looks as if she's been eating". (17) The parent continued to relate that "about once a week she would gorge herself - peanut butter sanwiches, ice cream, cake - just about everything in the house. Then she'd go in the bathroom and make herself vomit. The next day she'd eat even less than usual". The father expressed concern that his daughter was overdoing "running and jumping rope". (18)

Dr. Bruch feels that our "current national preoccupation with dieting and slimness plays a part in anorexia nervosa". (7) However, this is not the primary or only reason that a girl becomes anorexic. With the onset of her menses comes the realization that she is maturing. She begins to consider and often to fear the possibility of change as she begins to develop secondary physical characteristics, experience a first sexual encounter or perhaps move to a new high school or enters college. All of these events "threaten or challenge her and she is no longer in total control and she may then seek for a 'solution' in extreme dieting". (19) Oftentimes, covert tensions exist between the parents and "the young girl may feel responsible; she may feel that she is letting her parents down if she doesn't achieve success.....social, academic, or athletic". (20)

I would like to address myself to the case histories of the anorexic female patients treated in the therapeutic milieu in our Psychiatric Inpatient Unit. Many similarities will occur as the histories are related.

Our first patient, Ann, was 11 years old when admitted to our unit. She was a straight "A" student with an I.Q. of 133. Ann's parents were both chemists with advanced degrees and were heavily involved in the Church of Christ. Ann had a 13 year old "Learning Disabled" brother. He had been in special classes and recently had been put in some regular classes with Ann. Her classmates called him "dummy" and she seemed to resent having to be with him.

In relating her early history, Ann's mother stated that Ann was always a good eater, but that she herself was a "food pusher" and would consistantly urge Ann to eat "at least one small helping". Ann began to tantrum at the age of 3 1/2 years and the episodes would last 15 minutes. She was enuretic until age 7. Her mother felt that Ann was more verbal with her because she was more often available, but she would always go to her father for help with her homework.

Ann's parents were described by our social worker as a "concerned, cooperative, yet constricted couple". They seemed unable to discuss relevant material. The mother was "aloof and obessive" and the father was "passive".

Ann saw her parents as being very controlling. She stated that when she became angry and raised her voice, she was always sent to her room and had to apologize before she could come out. She wanted clothes like "the other girls have", but she had to wear the ones that her mother made for her. She seemed to feel herself to be in a constant conflicted state. She felt bad about the desires she had for herself as opposed to what was expected of her by her parents. Her response to this dilemma was to stop eating. She was now in control; she was the only one who would decide what would go into her mouth.

Ann was admitted to her local hospital in her far West Texas hometown complaining

of severe abdominal cramps five months prior to admission to Children's Medical Center. She had decreased her food intake and had been tube fed three months prior to her admission.

Often times a remark concerning her physical appearance or a change in primary relationships can trigger the anorexic patient's resolution to stop eating. In Ann's case it was both. While she was in her local school her notebook was stolen and she had to copy all of her work over again. She later discovered that her best friend had taken it and she felt betrayed. She also was accused by friends as being "fat" and they called her "Porkey Pig".

Ann was given a battery of psychological testing and I will relate general results as they are typical of all of our anorexic patients. She was a girl who had a desire to perform perfectly and she erased her answers many times while taking the test. Her test results indicated that she wished to remain pre-adolescent. She appeared to have a fear and distaste of sexual development. Sexual feelings and stimulation disarmed her and she became illogical and disorganized. Ann appeared to equate sexual feelings with physical disease and she dealt with her anxiety about sexuality by denying and avoiding her sexual feelings. Her distorted thinking was evidenced by her remark, "Eating can cause one to get pregnant".

Initially Ann's behavior on the Unit was very obsessive. She would stay in her room reading her Bible, writing poems, drawing pictures, and working crossword puzzles. She was constantly arranging her drawers in a meticulous manner. She would wash her clothes herself in a special way. If a peer touched any of her belongings, she exploded verbally because she didn't want them "messed up".

Not long after Ann was hospitalized, she was given a base weight to maintain.

It soon became evident that she was not going to maintain her weight and a behavior plan was devised for her by Dr. Ken Wiggins, Director of the Psychiatric Unit for Children's Medical Center, and Chief of Child and Adolescent Psychiatry at the University of Texas Health and Science Center, Dr. Mark Blotcky, a Psychiatry Fellow at that time, and the staff. Her privilege status depended upon her weight gain. Ann's plan and that of the three patients who followed her for hospitalization was essentially the same. (The weight is calculated in kilograms).

"Below 32 - will be tube fed, confined to room with bathroom privileges only.

32-32.9 - stays in room; gets same choice of snacks as rest of group, eats meals and snacks in room.

33-33.9 - will stay in room with bathroom privileges and still have meals in dining room.

34-34.9 - will have full On-Unit privileges including classes and snack choices.

35-35.9 - will be allowed outside group activities - on grounds,

36-36.9 - will be allowed off-grounds, class activities, (swimming, gym, museums, etc.)

37-37.9 - will be allowed to go on field trips (picnics, movies, skating, etc.)

Patient will continue to be weighed two times a week, on Tuesdays and Fridays.

Patient will be allowed to have food supplement "Sustagen" if she wants it".

Ann's weight upon admission was 57 lbs. and 83 lbs. when she was discharged. The nasogastric tube was inserted nine different times during her stay on our Unit. It was inserted for the first time when Ann had been hospitalized a month and much of her bizarre and manipulative behavior occurred around the tube feedings. When the tube was first inserted, she refused to eat or drink. She would not swallow

and carried around a Dixie cup to collect saliva. This tended to alienate her from her peers, as well as repulse them, thus reinforcing her isolation. She was so insulated and defended that she seemed not to notice.

Ann became very manipulative. In the early stages of her treatment the tube would "just happen" to come out several times a week and she would report that it "fell out". Initially she would have to be restrained for her feedings. She became so angry on one occasion that she grabbed her formula, threw it in the sink and hid in a cabinet in the dining room while a staff person prepared a second supplement. She was not allowed to go to the bathroom directly after a feeding as she would either vomit or attempt to remove the tube and drain it. On the mornings before Ann was to be weighed, she would attempt to drink large quanities of water until staff became aware of her activities. One particularly humorous maneuver attempted by Ann was to put a heavy iron bolt between her legs when she weighed. She seemed unaware that her strange "duck waddle" attempting to keep it in place would attract any attention.

Ann exercised constantly. She would spend her entire time during recess and at the park compulsively swinging. She would exercise immediately after meals in the girl's bathroom and would often jump rope.

Part of our milieu program includes weekly field trips and Ann had to be fed several times publically in the park. She was very indignant when the group went to the State Fair and she had to have the tube in her nose.

Classroom management for Ann was planned to challenge her intellectually and yet deal with her emotional problems. She was very compulsive and would check out her directions with the teacher each time before making a move. She would become

very disturbed if peers made noises or bothered her in any way. One of Ann's assignments was to tutor slower peers with their work. She became almost hysterical when she initially discovered this task on her written contract because she experienced it as an intrusion upon her time. She complained that she would never be able to get her work done.

Ann often would be late to class and Dr. Wiggins would advise staff members to be very direct with Ann when she delayed saying, "Why are you having so much trouble deciding to go to class? You seem more interested in doing something else". He urged us to point out that there was a disagreement, but that it was permissible to disagree and that she could "practice disagreeing."

Because Ann's speech was barely audible, she was required to give daily reports from the newspaper to her peers in the classroom. She would stand in a stooping position with her head across her chest and speak up only when peers complained. With much support from staff and peers she was finally able to speak clearly and her voice gradually lost its high, whiny quality.

Small children made Ann very uncomfortable, so a Child Care Course was designed for her and upon its completion she tutored the younger children in their classes.

Near the end of her hospitalization, Ann was much more relaxed in the classroom. She would come in, talk with her classmates before going directly to her desk and could deal with changes in scheduling without seeming to emotionally disintegrate. Classtime became a pleasant experience for her.

Ann was discharged after a hospitalization of 14 months with the following behavior plan:

> "1. Ann will weigh whenever she likes and will be in control of herself.

2. She will weigh with her parents on Friday. If under-

37 kg. - can not go with family on Friday night outing.

36 kg. - will be restricted to house from after school until Sunday morning.

35 kg. - will be restricted to house on weekends.

34 kg. - will be restricted to house and grounded after school until next weight day."

Our last reports were that Ann was maintaining her weight, had developed peer relationships, was involved in skiing and camping. She communicated with her primary staff for two years following discharge and reported that her parents had granted her many more individual freedoms.

Our second anorexic patient was an attractive blonde 12 year old girl named Carol, who began refusing to eat around her 12th birthday. Carol had a slumber party and reacted negatively to the physical development of her friends and to their weight. She clearly stated, "If I gain weight, I will get fat". She contacted flu and was hospitalized several times for tests to determine the reasons for her severe weight loss. She often had nightmares and suffered with insomnia. She wanted to sleep with her mother at night when she was frightened. Carol was admitted to our Unit weighing less than 55 lbs.

Carol's family was very active in their local church in a suburb of Dallas where they lived. Her parents were very strict with her. Carol had two brothers ages ten and six years old. The parents chose to share in very few activities by thmselves. They placed their children's needs and demands before their own, and "did very little without the children in their leisure time. If they did make

plans and "the children put up a fuss", the plans would be cancelled. Carol's father was the dominant one in the family. He would be the one to say "no" and the mother would confirm his decisions by silence. He felt that his children should automatically understand any limit he set with them; a decision which left no room for discussions about feelings. He seemed to think that he would be giving up his authority as the primary decision maker if he received each person's opinion. He had a very strong need for his children to behave in such a way as to prove that he was a good parent. The dynamics of Carol's family seemed to forbid differing opinions. In family therapy her mother would say "nothing's wrong", with tears in her eyes while the father "stormed" around. He verbalized his concerns that the family code of strictness and religious teaching had contributed to Carol's illness.

When Carol was first admitted, she was ingratiating and compliant and she interacted very little with peers. She would often draw pictures and give them to staff members. She verbalized "I love you" to almost everyone and was overly affectionate. She became very dependent upon female staff. Carol would look up at the ceiling rather than have eye-contact when she talked with anyone. She seemed to be continually debating internally before making a decision. She stated that her "conscience caused her lots of trouble".

After Carol had been on the Unit for a while her behavior regressed to that of a two year old child, and we began to experience what we were later to call "her screaming period". Carol suffered with a separation and individuation problem. She became symbiotic with whomever she was with and she could only respond to the immediate situation; any attempt to interact was seen as a threat to her autonomy. Carol could not deal with any situation that was not within her schema. She had trouble accomodating "because her past memory bank was deficient". She became

more verbal about her likes and dislikes, but seemed to experience no middle ground when she screamed out at people. She became volatile during this period and tantrumed several times. She made rude remarks to peers and staff and then she would scream and deny her actions when confronted.

Carol was tube fed and the nastrogastric tube was inserted six different times until her weight was over 55 lbs. She would pick at her food - eat one pea, one spoonful of potatoes and if she had a meat patty, she would pick out all of the fat particles and eat the miniscule parts remaining. As with Ann, we did not talk about food. She was always given the opportunity to eat without any remarks from the staff.

When Carol was in class, her work was typically methodical and precise. She was highly self-critical and expected perfection of herself which caused her to be painstakingly slow. She was able to work only in a highly structured classroom situation. Her academic contract consisted of short tasks which allowed her many small successes. She had to report on a daily news event and tell why she had chosen it and how she felt about it. She had to write paragraphs using open-ended sentences such as "How do you feel when your Mother asks you to do the dishes when your friends are waiting for you to go to the movies?" She had to write a diary each day consisting of three sentences. "I feel.....because.....". This is one of the most productive exercises we use on our Unit in the classroom. We use it for all of our patients and the material forthcoming is usually quite revealing of the patient's emotional state on that particular day.

Carol completed our Child Care Courses and tutored the younger patients. She worked with male peers on joint projects under much stress because she was afraid that she wouldn't be able to finish her work. We worked with her to help her

accept changes in her routine and to learn that she could remain internally intact even though her external world was not compulsively perfect.

Carol was hospitalized for twelve months. She was discharged with a treatment plan similar to Ann's; her privileges at home would be determined by her maintenance of a certain baseline weight. The family dynamics of relating seemed to be much improved when she left. Her mother was more verbal and had learned to be less controlling of Carol and her father appeared to be more aware of his feelings and how they affected his children. The last we heard from Carol, things were going well for the entire family.

Our next patient, Laura, was from the same West Texas bordertown as Ann and she and her family were members of the same Church of Christ; Laura knew Ann only slightly as she was several years older. Laura was a very attractive blonde who smiled most of the time and stood in a modeling stance as if she were on stage. She was an only child whose weight had decreased 26 lbs. in eight months. She was admitted weighing 71 lbs. Her mother reported that she had experienced a dramatic alteration in her personality patterns. She had always been "happy, carefree, and pleasant" and now she was "always irritable and oppositional". She complained of being so bored that she "didn't want to live!" Laura was preoccupied at home with meal planning and preparation, yet ingested very little food. She exercised excessively and would jump up and down even while studying. In school Laura was a straight "A" student. Her extra-curricular activities included singing, dancing, playing the piano, painting, writing and directing plays, and modeling. Her mother brought a large portfolio of professional photographs showing the development of Laura's career from a very early age.

The precipating event which triggered Laura's dieting was her concern over

her excessive weight while preparing for her school play. She had to wear a Hawaiian bikini costume and she felt she was "too fat".

Because Laura had perhaps the most unusual parenting of any of our patients in her formulative years, my focus will be on her family constellation. She lived with both parents and her maternal grandmother in Dallas until she was five years old. Her parents were then divorced and the mother, grandmother, and Laura moved to Ann's home town in West Texas.

Laura's father was a 33 year old nuclear physicist who was considered a "little strange" by her mother, (age 32 years), when they were married. She accepted his behavior thinking they would have an ideal marriage. However, he soon began exhibiting bizarre behavior. He never wanted her to invite company over; if anyone did come, he wanted to know why, and would then completely ignore them. He buried himself in his work. He had been working on a boat for 20 years in the backyard and this task served effectively to isolate him from everyone. He would not allow lights to be on in the house at night and on one occasion, he bought a gun and shot them out. After Laura was born, he refused to share any of his money with the family and Laura's mother had to go to work. She felt that he wanted a wife and child to present a public image as "an ideal family Man". His mother was an achiever who had been "Woman of the Year" in her local area and she was often a "world traveler" who always seemed to need recognition. Her husband was a lawyer who had deserted the family when Laura's father was three years old. When Laura was about three years old, her father lost his temper and "conked" her on the head with a wooden hammer because he was busy and did not want to be interruped. On another occasion he threw her across the room because she was "bothering him". When he did spend time with her, he would lie across the bed and tell her violent and bloody horror stories, which she loved, and take her to horror movies.

Laura's maternal grandmother remained a source of conflict in the home while Laura was growing up. She would oppose most discipline measures Laura's mother would take and would manage to sabotage them. Over the years Laura's mother acquiesced to the grandmother in order to avoid conflict. Laura reported that her grandmother would scratch any of her "funky" records that she didn't like or approve of. She made Laura wear two sets of underwear when it was cold and the girls at school laughed at her in gym class. When Laura tantrummed at home, her grandmother told her that she was probably "killing" her mother by upsetting her so much.

In her initial interview upon admission, she was very verbal and presented a very graphic description of how she experienced her own actions and thoughts: "I was too filled out and mature looking. None of my friends were as developed as I was. I weighed 95 lbs. and I was too fat - I felt weird - I told myself,'I will go on a diet; I can't go on like this'. At first I stopped eating cake. I still looked normal, so my Mom didn't think anything about it. Each time I lost a little, I'd think "this is neat, I'm able to cut down.' I wanted to show my friends and boyfriends and I wanted attention. It became a habit with me. I can't stop worrying. Each time I sit down I worry. Life is boring for me. I start worrying even when I am at the movies. There is nothing left in life for me - I get bored - I have to be doing something all of the time."

In school Laura had always been a compulsive student. When she was in the first grade, she wouldn't do work until she saw how other peers did their's for fear of making a mistake. She was always a perfectionist and an over-achiever. If an assignment called for three lines, she would write three pages.

Generally when patients are first admitted to our Unit, they do not see their parents for six weeks in order that they can form an alliance with staff members

and begin a trust relationship. This is necessary for the patient to begin to share feelings. When Laura finally realized that she was going to remain on the Unit, she began to verbalize that she knew what her problem was and that she was going to immediately begin to eat and "be well"! She would go from one staff member to another with this startling "up front" revelation and each of us thought we were the chosen one to have affected a quick cure. She also used this ruse on several unspecting medical students and Psychology Interns training on our Unit. This manipulative behavior is common to anorexic patients and Laura used her theatrical talent well.

Exercise was always a predominant part of Laura's day. Her movements were reported as always "on the run". She would exercise in the gym sometimes for an hour and would dance vigerously at every opportunity. Staff would interrupt her exercise often and invite her to play games. She would always resent this intrusion.

When Laura first worked in the classroom, she would stand in one place until asked by the teacher to sit down and only then would she sit at her desk. She would continue to sit after class was over until the teacher directed her to leave. She would work the entire class period on one task on her academic schedule even though she had several to complete. During the period her weight was declining, she would come to class wearing her coat and gloves and complaining bitterly of being cold all of the time, which in reality she was! Laura's work in the classroom was essentially the same as Ann's and Carol's.

Laura was gradually able to complete all of her assignments by making less detailed reports, writing in a less constricted manner and in time, would allow herself to make mistakes without castigating herself so much. She became more aware of her classmates as persons and seemed to enjoy her interactions with them. We

knew she was getting well when she began to be "silly" in an age-appropriate manner in class and when she began to have "sit-outs" and asserting herself and breaking minor rules. A point of joy for all of us who work with anorexic patients is realized when they begin to experience "sit-outs". (The patients are required to "sit-out" in the hall for a certain length of time if their actions interfere with another's learning process or if they break Unit rules.) The infractions for the anorexic patients are usually minor, but they seem to know too, that a "sit-out" means that their autonomy is emerging.

Curiously, Laura chose to exhibit only two of her talents while on the Unit. She was very creative in the weekly Psychodrama sessions and in the Skill's Training skits which were video-taped. She was a very creative dancer and jazz was her speciality. The rest of our population loved dancing with her and learning from her, so essentially, again she was "on stage", but she did not seem to perceive it to be that way. She often stated that she was so happy that someone was not expecting her to "perform" all of the time.

Laura gained 26 lbs. during her seven month stay on our Unit without having to be tube-fed. During her hospitalization, her mother began to develop interests of her own, changed careers, and found a satisfactory home for her mother whose health had been steadily declining. She seemed now ready to focus in on her life rather than just Laura's. Laura and her mother recently visited our Unit and both looked "an all encompassing wonderful" and things seemed to be going well for both of them.

Our last patient, Donna, was different from the other girls in that she was admitted to our Unit on three different occasions. She was a very pretty, petite, nine year old with dark hair and the classic "big brown eyes". She seemed so fragile and so pathetic that just being around her aroused maternal and paternal

feelings of protection in nearly everyone. She immediately triggered the "helper syndrome" indigenous to most of us in the Mental Health field. We really had to polish our defensive armors to withstand her wiles of helplessness.

Donna's parents had their own business in a small town not far from Dallas. One day the family was swimming and Donna's father noticed how thin Donna was getting. The parents questioned Donna and found that she had been eating very little. She told them that her babysitter, who was rather heavy, told her that if she did not stop eating so much, she would be as fat as she was. Donna also reported that some of her schoolmates had begun to tease her about being "fat". She lost 18 lbs. in three months.

Donna was the only child of two intense, controlling, and protective parents. My mental flashbacks pictured them as nearly always being tearful. The separations after visits were extremely stressful; <u>everyone</u> was crying! Donna would always beg her parents to take her home and oftentimes a staff person would have to intervene and help them put a definitive closure to their "good-byes".

While Donna was in school, her mother was very involved in her activities and made many trips to school to check on Donna's functioning and well being. Donna's father was often away from home on business trips.

When Donna was first admitted, we were able to witness a rather interesting evolution of emotions and actions which our male population experienced. Initially, we would see first one and then another protectively holding her hand and attempting to comfort her when she cried, (which was often!). We had to intervene to keep the older boys from carrying her around. This action continued for several days and with all of their "tender loving care", she still whimpered and cried. They began to be puzzled that she wasn't responding to this attention. Their puzzle-

ment then turned to anger and finally disgust. They were very verbal with her on the milieu and in Group Therapy and finally the constant crying subsided. She seemed concerned how others felt about her and this was one of the times our "milieu magic", which depends upon peer pressure and role modeling, seemed to work.

Donna was very constricted in her movements and in her conversations. She could never directly come out and say "I want...". Everything was posed as a question or something she "just happened to wonder about". Most of our patients constantly beseige Dr. Wiggins to let them go home and Donna was no exception. Her only difference was that she wouldn't talk to him. She would follow him around and he would make himself available, but she just couldn't seem to say the words until she had been on the Unit for several months. We would often see her just standing on the periphery of activities - she would stand outside of the T.V. room- outside of the nurse's station - outside of the gym, seemingly waiting for someone to direct her next move. She would stand and sway. On a field trip to the Zoo, her peers said " here is Donna" as they pointed to the elephant swaying back and forth to digest his food.

On our Unit, we think of our paradigm as being "eclectic". We examine theories, try different approaches, and then use the ones that work. However, we consistantly use a behavior system of "levels" for the activities of our patients. It is as follows:

Level IV - Patient may go off-grounds on field trips

Level III- Patient may go outside, but must be involved in activities which can be reached by walking

Level II - Patient must remain on Unit

Level I - Patient will have special individualized program divised by the Director and Staff

A weekly meeting is attended by the psychiatrist, psychologist, head nurse,

social worker, teacher, and the child care workers. The levels are assigned after a child's weekly behavior has been assessed.

In Donna's case, Dr. Wiggins devised a plan for her involving the Level System. She would be weighed each day and if she gained, she would be on Level IV. If she remained the same, she would be on Level III and if she lost, she would be on Level II. When her weight dropped to 50 lbs., the tube would be inserted. During the 39 days of this first admission, she was tube fed 2 times.

Prior to her second admission, Donna had been at home for a month. During this period her mother was hospitalized in Dallas. Donna went to school for the first two weeks; then she began staying home, remaining in her pajamas most of the time. Neighbors and family members began to bring in food. Donna's father would come home and find that Donna had cleaned out the refrigerator and thrown the food away. The last week before this admission, she ingested neither liquids nor solids. She weighed 46 lbs.

In the classroom, Donna had to be directed to sit down at her desk or she would just stand. Dr. Wiggins suggested that we ask her if she wanted to "stand or to sit?", and then to reinforce her actions by affirming, "It looks like you did what you wanted to do". Once seated, Donna was very passive. She would begin to work on a project and would not proceed without direction for each step. She would sit at her desk never asking for help when she needed it. She would not ask the teacher to check off her work. We tried several techniques with her and finally found one that would work. We would not check off her work unless she asked and if it was not checked off, she would have to come back to class and make time up in the afternoon while her peers were doing other "fun" things.

We use primarily Montessori materials in our classrooms because they fit so well with the Piagetian philosophy of "learning by doing" and one of the language exercises is to act out different verbs such as "smiling, jumping, hopping, etc.". Donna had to do this with a peer and it was never easy for her - but she did it. One of the most difficult tasks for her was to execute a skit during "Behavior Class". Each student had to devise the "wrong way" and then the "right way" of a particular behavior. She had trouble thinking of one, choosing classmates to help her, and finally, in just being heard!

Even though her I.Q. was "bright normal", Donna seemed "confused" a great deal of the time and could not complete many tasks during her school day. However, she steadfastly began to gain weight.

When I think of Donna on the Unit during this time, I think of the tune, "I love you in the morning, I love you in the evening, etc." With her it was "water"! She drank it "in the morning, at noon, in the evening, and even in the middle of the night". The evening staff reported that she would come up before dawn and want to be weighed and it would be obvious that she had been drinking water. She would always drink water in the morning before being weighed, and on one occasion she threw up three times because she drank such large quantities. She couldn't retain the excessive amounts, but she kept on trying!

Donna had to be tube fed three different times during this second admission and she would verbalize how frightened she was of being weighed. Several times I had to physically put her on the scales and she would say, "I'm so scared". She knew the tube would go in each time she dropped below her baseline weight. She was always innoviative in her attempts to tip the scales when I had to weigh her. She would wear shoes, her robe and even two pair of socks. I would always have to check her as she would look directly at me and tell me she only had on one pair. We would discover her

in the bathroom studying her profile and pressing in her abdomen as if trying to make it vanish. Mysteriously, Donna's underpants began to disappear. She finally admitted that she was throwing them away. She didn't want to wear them because they would make her too fat. Donna was discharged for the second time with a weight gain of 26 lbs. and looked very well. We were all so proud of her!

Within a month, Donna was admitted for the third time weighing 44 lbs. She had lost 15 lbs. The child psychiatrist who had been working with her requested that she be hospitalized with us again until she could be placed in another facility similar to our's which had an open campus and treated less severely disturbed patients. The family dynamics had changed somewhat and he felt she would be able to function satisfactorily in that setting. The Mother was now home from the hospital and was being treated on an out-patient basis. The parents had begun to recognize their anger with Donna for not eating and were dealing with it more openly. Donna was expressing her anger with her father for being out of the home so much when he was traveling and "leaving all of the work" for her mother and her to do. She was equally belligerant with her mother telling her to "get off my back" and to "shut up"! Donna at first said she stopped eating because "she didn't like her mother", and finally, "because I don't like myself".

During Donna's last hospitalization, she remained on her behavior plan. The tube was inserted several times and she was tube fed until the day of her discharge.

Her therapist, who often sees patients on the Unit, reported that he thinks her prognosis is "good", but that she had "a long road ahead of her".

Most anorexics fight a life-long battle and some lose. The most recent fatality was reported in April of this year, (1980). A 23 year old student nurse who was a volunteer participating in a routine sleep experiment at the National

Institute of Health died of "a cardiac arrest brought on by self-induced vomiting". (11) She had experienced cardiac arrest on two previous occasions which her doctors believed "were a direct result of her vomiting". (12) Had she reported these facts, she "would never have been admitted to the volunteer program".

We continue to hope that our patients will remain in the 90% range of those who survive.

FOOTNOTES

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